STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676352	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonemere Rehabilitation Center	11855 Lebanon Road Frisco, TX 75035

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents in 10 of (108, 117, 118, 120, 121, 218, 224, 227, 231, 238) of 62 resident bathrooms reviewed for environment. The facility failed to ensure 10 (108, 117, 118, 120, 121, 218, 224, 227, 231, 238) rubber shower [NAME] were properly glued down to ensure a safe environment. This deficient practice could place residents at risk of a diminished quality of life due to an unsafe and unmaintained environment. Findings included: Observations on 03/05/2024 between 12:02 PM and 1:15 PM, revealed the rubber Shower Dam (used in roll in showers to stop water from moving past the shower area to the rest of the bathroom floor), in rooms #224, #227, and #238, were not completely glued down. The rubber Shower [NAME] were attached to the floor on each end and the glue in the middle appeared to have failed and allowed the rubber strip to move two - three inches in each direction. Observations on 03/06/2024 between 7:31 PM and 8:00 AM, revealed the rubber Shower Dam in rooms #108, #117, #118, #120, and #121, were not completely glued down. The rubber Shower [NAME] were glued to the floor on each end and the glue in the middle appeared to have failed and allowed the rubber dam to move two - three inches in each direction. In an interview on 03/05/2024 at 12:02 PM, a resident who resided in room [ROOM NUMBER] said staff assisted her shower to the shower but she could shower on her own. She stated she had not noticed that the rubber dam was not completely attached to the floor in the shower. She said she if her foot got caught on it, she could trip. She said the shower chair could also get tangled in the loose rubber dam. In an interview on 03/06/2024 at 7:31 AM, a resident who resided in room [ROOM NUMBER] said she only required staff to turn the shower was able to do the rest herself. She stated she had not noticed that the rubber dam was not completely attached to the floor in the shower. She said the loose rubber could cause her to trip while in the shower. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/2024 at 8:30 AM, ADON B stated she was not aware of the loose Shower [NAME]. She said she completed Concierge Rounds for rooms #234 - #239 and did not check the shower in the rooms. She said they were definitely a trip hazard for residents who were able to walk into the shower on their own. She said they were a safety concern because shower chairs could get caught on them as well. She said staff were instructed to log any maintenance concerns in the logbook at the nurse's station. She reviewed the Maintenance Logbook between the dates of 12/19/2023 - 03/05/2024 with this surveyor and found no record of loose Shower [NAME]. In an interview on 03/06/2024 at 9:19 AM, the Maintenance Director said he did have problems with securing the Shower [NAME] to the floor. He said they required an epoxy glue that needed to and when he repaired them he placed signs on the bathroom door for staff not to use the shower until the glue had dried, but staff removed the signs and used the showers anyway. He stated he needed to find an alternate fix because he was constantly gluing them down. He said they needed to be secured to the floor to prevent the risk for residents or staff tripping on them. He said staff were required to enter any maintenance issue in the logbook and he checked he book daily to address needed repairs. He said he initialed the logbook when repairs had been completed. He stated there were no entries in the Logbook for him to repair shower [NAME] between 12/19/2023 - 03/05/2024. He stated sometime staff would stop him in the hall to tell him of maintenance issues and that could be why the issue was not logged in the Maintenance Logbook. In an interview on 03/06/2024 at 1:15 PM, the Housekeeping Director stated she completed Concierge Rounds for rooms #215 - #217 and had not noticed the loose Shower Dam in room [ROOM NUMBER]. She stated she checked for maintenance issues and resident concerns. She said she had not thought to check the bathrooms. She said she would log the issue in the maintenance log for repair had she seen it. She said it was a safety concern as residents could trip and fall. In an interview on 03/06/2024 at 1:25 PM, the Administrator stated he expected staff to note any maintenance concerns in the Maintenance Logbook at the nurses' stations and Maintenance staff to address the concerns timely. He said he also implemented Concierge Rounds, where facility management were assigned rooms to check daily. He said management staff had a form to complete for each room which addressed environment, safety issues, and clinical and dignity issues. He said each manager brought their forms to the morning meetings where concerns were discussed and follow up planned. He said he had not been made aware of the loose Shower [NAME]. He stated they were a safety concern in that residents and staff could trip on them. In an interview on 03/06/2024 at 2:15 PM, LVN D stated she completed Concierge Rounds for rooms #224 - #227 and had not noticed the loose Shower [NAME] in rooms #224 and #227. She said and maintenance issues should be logged in the maintenance log for repair. She said the loos rubber on the floor in the shower posed a safety risk to residents because they could trip. In an interview on 03/06/2024 at 2:32 PM, the Executive Assistant stated she was responsible to complete Concierge Rounds for rooms #228 - #233. She said the purpose of completing rounds daily was to identify any issues the resident may have or concerns with the room. She said she last completed the rounds about 8:40 AM on 03/06/2024. She said she had not noticed the loos Shower Dam in room [ROOM NUMBER]. She stated it could be a safety risk for residents because they could trip on the loose rubber. (continued on next page)

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/2024 at 2:45 PM, the LVN E stated she completed Concierge Rounds for rooms #120 - #124 and had not noticed the loose Shower [NAME] in rooms #120 and #121 when she completed rounds on 03/05/2024 and 03/06/2024. She stated one of the purposes of Concierge rounds was to ensure the rooms were safe, but she did not think to check the shower. She said the loose rubber on the floor, in the shower was a safety concern to residents as they could trip. In an interview on 03/06/2024 at 2:50 PM, ADON C stated she completed Concierge Rounds for rooms #106 - #112 but had not noticed the loose Shower Dam in room [ROOM NUMBER]. She stated it the [NAME] were not glued down and were loose, the posed a safety risk to residents and staff. In an interview on 03/06/2024 at 3:05 PM, the DON stated Concierge Rounds were done daily to help to identify maintenance issues, ensure quality and address any concerns residents may have. She said any concerns would be addressed in their morning meeting and maintenance concerns should be logged in the Maintenance Logbook at the nurses' station. She said any loose rubber in the showers posed a safety risk to residents as they could trip. Record review of the Maintenance Logbooks between the dates of 12/19/2023 and 03/05/2024 reflected no record of loose Shower [NAME]. Record review of the facility's policy, titled, Hazardous Areas, Devices and Equipment, reviewed December 2023, reflected All hazardous areas, devices and equipment in the facility will be identified and addressed appropriately to ensure resident safety and mitigate accident hazards to the extent possible. Identification of Hazards 1. A hazard is defined as anything in the environment that has the potential to cause injury or illness. Examples of environmental hazards include, but are not limited to: a. Equipment and devices that are left unattended or are malfunctioning; b. Devices and equipment that are improperly used or poorly maintained; c. Sharp objects that are accessible to vulnerable residents; d. Open areas or items that should be locked when not in use; e. Irregular floor surfaces (cords, buckled carpeting, etc.); f. Objects in the hallways that obstruct a clear path; g. Access to toxic chemicals; h. Insufficient lighting or glare .

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that each resident is free from the use of physical restraints, unless needed for medical treatment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview and record review the facility failed to ensure residents were free from physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms for 1 of 8 residents (Resident #5) reviewed for freedom from physical restraints. - The facility failed to obtain consent, physician's order, and care plan for Resident #5's full bed rails in which the resident movements were restricted and there was no documentation the restraints were required to treat his medical symptoms. This failure could put residents at risk of unnecessary restriction of their freedom of movement (any change in place or position for the body or any part of the body that the person is physically able to control). Findings included: Record review of Resident #5's admission record dated 03/07/24, revealed a [AGE] year-old male admitted to the facility 12/13/22 and readmitted on [DATE]. Admitting diagnoses included, senile degeneration of the brain (trouble remembering; difficulty paying attention, difficulty communicating with people, challenges related to reasoning, judging situations), repeated falls, legal blindness, muscle wasting, lack of coordination and dementia (the loss of cognitive functioning, thinking, remembering, and reasoning). Record review of Resident #5's Quarterly MDS, dated [DATE], revealed the BIMS score was blank. Further review of the MDS, revealed: Section E: Behavior: E0100. Potential Indicators of Psychosis: Z. None of the above (delusions or hallucinations). E0200. Behavioral Symptoms: A. Physical behavior symptoms directed towards others - Behavior not exhibited, B. Verbal behaviors symptoms directed towards others - behavior not exhibited, C. Other behavioral symptoms not directed towards others - Behavior not exhibited. E0900: Wandering - 0 (Behavior not exhibited). Section G: Functional Status. G0300: Balance during transitions and walking: A. Moving from seated to standing position - 88 (Not attempted due to medical condition or safety concerns). E. Chair/bed-to-chair transfer: The ability to transfer to and from a bed to a chair (or wheelchair) - Helper does ALL of the effort. Resident does none of the effort to complete the activity. Section P0100: Physical Restraints: Not used. Record review of Resident #5's Care Plan initiated 01/29/24 reflected, Focus I use enabler(s) (1/2 rails) related to family request. Goal, I will remain free of complications related to enabler including contractures, skin breakdown, altered mental status, isolation or withdrawal through review date. Interventions, Anticipate and intervene for potential causes which have precipitated prior falls or accidents. Discuss and record with me (DON), family, caregiver. Ensure valid consent on chart prior to initiating enablers. The full side rails were not care planned. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #5's enabler utilization assessment effective date 10/13/23 and signed 10/13/23 reflected the resident was assessed for 1/4 side rails on both sides of the bed per family request. Record review of Resident #5's enabler utilization assessment effective date 11/14/23 and not signed reflected an handwritten note that stated the family insistent of full rails. The assessment did not reflect who completed it. Observation of 03/06/24 at 12: 42 PM revealed CNA Q assisting the resident to get in bed. CNA Q explained to the resident what she is doing and after placing the resident in bed CNA Q pulled up full side rails on both sides of the bed, lowered the bed and placed a fall mat besides the bed. Resident #5 was not observed moving in bed or trying to get out of bed. In an interview on 03/06/24 at 12:01 pm, with Resident #5's responsible party she stated the family pushed for the full side rails, and they wanted the resident to have the full side rails because of the constant falls. She stated since the resident had the side full rails there had not been any reports of fall. She stated they will continue to push the facility for the full side rails even if it made to take and extra step. In an interview on 03/06/24 at 12:03 pm with LVN O revealed she was the charge nurse for the resident. LVN O stated Resident #5 required total assistance with activities of daily living. Resident #5 was legally blind, non-verbal, and heard of hearing. Resident #5 was a high risk for fall and had prior history of falls by trying to get out of bed. Resident #5 was not ambulatory and required assistance with transfers. LVN O stated full side rails were used on Resident #5 to prevent the resident from falling and had not witnessed the resident trying to get out of bed when the side rails were up. LVN O stated Resident #5 was on hospice and hospice provided the bed with the full side rails. LVN O stated she did not remember when the resident started using the full side rails. LVN O stated there was potential for injury if the resident got trapped in the rail, but the resident had not tried to get out of bed and there had not been reports of fall since Resident #5 started using the full side rails. LVN O stated there was supposed to be an order and care plan for the full side rails, and she was not aware why Resident #5 did not have the order and care plan. LVN O stated she did no know who got the order for the full side rails or completed the full side rails consent. In an interview on 03/06/24 at 01:36 pm with CNA Q revealed she provided care to Resident #5. CNA Q stated Resident #5 was not oriented, he was confused, he required total assistance with activities of daily living. Resident #5 initially he was ambulatory but had declined to using a wheelchair, he was weaker and required two staff to assist with transfer. Resident #5 was a high fall risk and had prior constant fall, he would slide out of the chair because of constantly moving and from bed he would slide out. CNA Q stated Resident #5 was constantly moving in bed and at times he would be sideways but not in the rails. CNA Q stated she had not witnessed Resident #5 trying to climb over the rails or being caught in the rails. CNA Q stated she had not witnessed Resident # fall. In an interview on 03/06/24 at 02:19 pm with LVN R revealed she was not aware Resident #5 had full side rails. LVN R stated she was the one responsible to update the care plan, but she was to receive the information from the nursing department for her to be able to update at the care plan. LVN R stated since this was a new care plan for full side rails the nursing department were to initiate the care plan. LVN R stated the care plan was needed to make sure the resident goal and interventions were met. (continued on next page)

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F 0604 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/06/24 at 04:06 pm with the DON revealed she was aware of Resident #5 having the full side rails. The DON stated initially Resident #5 had 1/4 side rails, and the responsible party talked to the hospice company who brought the bed with full side rails. The DON stated the facility had informed the resident's family it was against the regulation to use the full side rails, but the family declined and insisted for the resident to use the full side rails. DON stated the family's rationale was that the resident hadn't had a fall from bed since the resident started using the full side rails. The DON stated she was the one who talked with the family and got the consent for the full side rails and at the time she explained to the family the risk of using the full side rails. The DON did not remember the time she got the family consent, but per the enabler utilization assessment effective date was 11/14/23 for the full side rails. The DON stated she was responsible on making sure the full side rails were care planned and there was an order for the full side rails. The DON stated an order was required for any equipment used by the resident, so that the staff were able to monitor for the effectiveness. The DON stated the care plan was required to show the resident's needs, and to help meet the resident's needs, also to the staff to be able to monitor the resident when side rails in use. Record review of the facility policy revised 2023 titled, Use of Restraints, reflected, Restraints shall only be used for safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Restraints shall only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience or for the prevention of falls.1.Physical Restraints are defied as any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual can not remove easily, which restricts freedom of movement or restricts normal access to one's body. 4. Practices that inappropriately utilize equipment to prevent resident's mobility are considered restraints and are not permitted including: a. Using the bedrails to keep a resident from voluntary getting out of bed as opposed to enhancing mobility while in bed;. 9. Restraints shall only be used upon written orders of a physician and after obtaining a consent from the resident and/or representative (sponsor). The order should include the following; a. The specific reason for the restraint (as it relates to the resident's medical symptoms) b. How the restraints will be used to benefit the resident 's medical symptoms. c. The type of restraint, and the period of time for the use of the restraint.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based on observation, interview, and record review the facility failed to ensure residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record and PRN orders for psychotropic drugs are limited to 14 days. Except if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order for 2 (Resident #15 and #75) of 8 residents reviewed for PRN orders for psychotropic drugs. Resident #15 had one active PRN orders for anti-anxiety medication (Lorazepam) with order start dates of 11/16/23 and did not have an end date. Resident #75 had one active PRN orders for anti-anxiety medication (Lorazepam) with order start dates of 12/15/23 and did not have an end date. These failures could place residents at risk of receiving unnecessary psychotropic medications with possible medication side effects, adverse consequences, decreased quality of life, and dependence on unnecessary medications. Findings included: Record review of Resident #15's admission record dated 03/07/24 revealed an [AGE] year-old female initially admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses that included, but were not limited to, anxiety (is a feeling of fear, dread, and uneasiness), hypertension (when the pressure in your blood vessels is too high), gastrostomy status (a tube inserted through the belly that brings nutrition directly to the stomach), aphasia (a disorder that affects how to communicate), lack of coordination and dysphagia (difficulty swallowing). Record review of Resident #15's quarterly MDS completed on 12/27/23 revealed a BIMS left blank and indicated severely impaired cognition. The MDS did not indicate the resident using the medication. Record review of Resident #15's care plan did not have the antianxiety medication care planned. Record review of Resident #15's active orders dated 03/06/24 revealed the following order: Lorazepam Oral Concentrate 2 MG/ML (Lorazepam), give 0.5 ml via G-Tube every 4 hours as needed with an order date of 11/16/2023. During an observation and interview on 03/06/24 at 11:00 AM revealed Resident #15 was lying in bed on her back bed in low position. Resident #15 had a trachea and a g-tube, her eyes were closed, and no distress was noted. Resident #15 was not interviewable. (continued on next page)

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Record review of Resident #75's admission record dated 03/07/24 revealed [AGE] year-old female initially admitted to the facility on [DATE] with diagnoses that included, but not limited to, hemiplegia (complete paralysis) and hemiparesis (partial weakness) following cerebral infarction affecting right dominant side, aphasia (a disorder that affects how to communicate), Type 2 diabetes and dysphagia (difficulty swallowing). Record review of Resident #75's quarterly MDS completed 02/15/24 revealed BIMS blank and indicated Resident #75 cognitive skills for daily decision making was severely impaired. The MDS did not indicate the resident using the medication. Record review of Resident #75's care plan did not have the antianxiety medication care planned. Record review of Resident #75's active orders dated 03/06/24 revealed the following order: Lorazepam Oral Tablet 0.5 MG (Lorazepam) give 1 tablet by mouth every 4 hours as needed for Agitation, with start date 12/15/23. There was no end date for the medication. During an observation and interview on 03/06/24 at 10:25 AM revealed Resident #75 was in bed awake. Resident #75 had a g-tube, and she was non-verbal. In an interview on 03/07/24 at 11:06 AM with the DON she stated she was the one responsible to make sure the 14 days PRN antipsychotic medications were addressed timely. The DON stated she missed to address the PRN medications and she was going to follow up with the resident's primary care provider so the residents could be assessed for the new orders. The DON stated she did not have any other staff who was responsible to review and make sure the PRN antipsychotic orders were addressed. She stated the PRN antipsychotic medications were to be review timely to determine if the resident required the medication. The DON stated the failure of the PRN medications not reviewed timely put the residents at risk of taking medication that they might not required to take. Record review of the facility policy revised December 2023, titled Antipsychotic or Neuroleptic medication use, reflected, .14. The need to continue PRN orders for psychotropic medications beyond the 14 days requires that the practitioner to document the rationale for the extended order. The duration of the PRN order will be indicated in the order. 15. PRN order for antipsychotic medications will not be renewed beyond the 14 days unless the healthcare practitioner has evaluated the resident for the appropriateness of that medication.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37193 Based upon observation, interview and record review the facility failed to ensure drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and under proper temperature controls for 4 (Resident #1, Resident #8, Resident #13, and Resident #57) of 38 and 1 of 3 medication carts (200 Hall Nursing Cart) reviewed for drug labeling and storage. - The facility failed to ensure the 200 Hall Nursing Cart Nursing Cart did not contain an in-use insulin pen for Resident #1, Resident #8, Resident #13, and Resident #57 with no open date. This failure could place residents at risk of adverse medication reactions and drug diversions. Findings included: Record review of Resident #1's admission record dated [DATE] revealed a [AGE] years-old female, initially admitted on [DATE] and readmitted on [DATE]. Admitting diagnoses included, but not limited to: Type 2 diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), dysphagia (difficult with swallowing) anxiety, chronic pain and dementia. Record review of Resident #1's physician orders dated [DATE] revealed an active order of Humalog Kwik pen 100unit/ml to administer per sliding scale, order date [DATE]. Record review of Resident #8's admission record dated [DATE] revealed an [AGE] years-old female, admitted to the facility on [DATE]. Admitting diagnosis included, but not limited to, dysphagia (difficult swallowing, chronic kidney disease, muscle wasting and gastro-esophageal reflux disease without esophagitis (happens when acidic stomach contents flow back into the esophagus) Record review of Resident #8's physician orders dated [DATE] revealed an active order of Humalog Kwik pen 100unit/ml to administer per sliding scale, order date [DATE]. Record review of Resident #13's admission record dated [DATE] revealed an [AGE] years-old female, admitted to the facility on [DATE]. Admitting diagnoses included, type 2 diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel) dysphagia (difficulty swallowing), dementia (the loss of cognitive functioning, thinking, remembering, and reasoning), anxiety (feeling of fear, dread, and uneasiness), hypertensive (High blood pressure, also called hypertension) and speech and language deficit. Record review of Resident #13's physician orders dated [DATE] revealed an active order of Insulin Glargine Subcutaneous Solution Pen-injector 100 UNIT/ML (Insulin Glargine) Inject 15 unit subcutaneously in the morning for DM, order date [DATE]. (continued on next page)

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Record review of Resident #57's admission record dated [DATE] revealed an [AGE] years-old female, admitted to the facility on [DATE]. Admitting diagnoses included, acute pain, morbid obesity, type 2 diabetes (condition that happens because of a problem in the way the body regulates and uses sugar as a fuel), epilepsy (disorder of the brain characterized by repeated seizures) and pneumonia (inflammation and fluid in your lungs caused by a bacterial, viral, or fungal infection). Record review of Resident #57's physician orders dated [DATE] revealed an active order of HumuLIN R Injection Solution 100 UNIT/ML Insulin Regular (Human)) Inject 15 unit subcutaneously with meals for DM Hold if BS <125, order date [DATE] and HumuLIN R Solution 100 UNIT/ML (Insulin Regular Human) Inject as per sliding scale, order date [DATE]. In an observation and interview on [DATE] at 11:34 AM, inventory of the 200 Hall Nursing Cart with LVN P revealed: insulin Kwik pen were in the cart and the insulin pens were noted dated the open dates, Lispro Kwik pen for Resident #1, Lispro Kwik pen for Resident #8, Lantus Kwik pen for Resident #13 and Humulin R Kwik pen for Resident #57. LVN P said nursing staff are expected to check their carts daily for inappropriately labeled medications. She said insulin must be labeled with the date opened in order to track the expiration date because when insulin expired it becomes less effective. LVN P said since the insulin pen did not have an open date it must be discarded in the sharp's container because use of expired insulin could place residents at risk for uncontrolled blood sugars and not being effective. In an interview on [DATE] 01:08 PM, the DON said nursing staff are expected to check their carts daily at the beginning of their shift to make sure they did not have expired medication, and the insulin was supposed to be dated and discarded after 28 days. She said ultimately the ADON, DON were responsible for ensuring the carts are monitored and perform audits of carts every other week to ensure nursing staff maintained their carts, there was no documentation of the audits. The DON stated the insulin could be ineffective or change to a different consistence which could be harmful to the resident. Record review of the facility policy titled Storage of Medications revised ,d+[DATE] revealed, . 4. The facility shall not use discontinued, outdated, or deteriorated drugs or biological. All such drugs shall be returned to the dispensing pharmacy or destroyed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	676352	A. Building B. Wing	03/07/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Stonemere Rehabilitation Center	11855 Lebanon Road Frisco, TX 75035

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food safety in the facility's only kitchen. The facility failed to ensure food items in the walk-in cooler and dry-storage areas were stored away from soiled surfaces and airborne contaminants. The facility failed to ensure kitchen equipment (Ice Machine, Coffee Maker, free standing Fans) were free of airborne contaminants. These failures could place residents, who received food from the kitchen, at risk for food contamination and food-borne illness. Findings included: An observation on 03/05/24 08:25 AM revealed the vents on both sides of the Ice Machine covered with black dust and fuzz. The vent on the left side faced a food preparation area and the vent on the right side of the Ice Machine faced a drink dispenser, drink dispenser gun, and ice scoop. The insulated coolant hose in the walk-in cooler was observed to be covered in thick, moist black dirt and fuzz. The hose ran the length of the walk-in cooler and was directly above food stored on shelves in the cooler. An observation on 03/05/24 08:35 AM, in the dry food storage room, revealed three covered bins, one labeled cornmeal, one labelled breadcrumb, and one labeled brown sugar. Dust and food particles were observed on the lids. A free-standing fan in the corner of the kitchen pointing toward the cooking area had a buildup of dust and fuzz on the blades and the front and back blade cage. The fan was not on at the time of observation. An observation 03/07/24 11:45 AM revealed the vent on the top of the coffee maker covered with black sticky fuzz. A second free standing fan placed on top of the food warmer had dust and fuzz on the blades and the blade cage. The fan was not on at the time of observation. A measuring cup was observed in a bin containing rice, in the cooking area. (continued on next page)

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	676352	A. Building B. Wing	03/07/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/05/24 08:25 AM, the Dietary Manager and Corporate Dietician said the [NAME] machine was cleaned daily. They said there should not be any dirt or dust on the vents because it could be dislodged and contaminate food in the prep area or near the drink dispenser. They stated the black dust built up on the insulated coolant hose in the walk-in cooler posed a risk of food contamination as it could get into food stored immediately below the hose or anywhere in the cooler. The Dietary Manager said the lids on the three bins containing breadcrumb, brown sugar, and cornmeal should be kept clean to prevent any dirt or food particles from contaminating the produce when staff opened the lids. He stated the fan on the floor facing the cooking area was used to help cool the kitchen. He said his should be free of any dust to prevent any air-borne contaminants. The Dietary Manager said the walk-in cooler was cleaned after each delivery, but he had not noticed the grime buildup in the refrigerant pipes. In an interview on 03/05/24 02:52 PM, the Administrator stated he expected the Dietary Manager to ensure kitchen equipment was kept clean and food was stored appropriately to ensure residents were not exposed to contaminated food or food borne illness. In an interview on 03/07/24 07:31 AM, the DON stated she expected kitchen staff to store and prepare food according to professional standards. She said equipment should not have a buildup of dust because it could blow onto food. She said the kitchen should be maintained clean and sanitary to prevent food contamination and food-borne illness to the residents. In an interview on 03/07/24 11:45 AM, the Dietary Manager said the fan on top of the food warmer was used to help cool the kitchen and should be free of any dirt and dust to prevent it from getting into food and a potential for food- borne illness. He said the vent on top of the coffee maker should also be clean and free of dust build up because when the fan ran, it could blow dust into food. He stated the measuring cup stored in the rice bin posed a risk to contaminate food and should not be left in the bin. He stated staff were expected to sign off on kitchen cleaning tasks, on the cleaning schdule. He said he was responsible to train and monitor kitchen staff to ensure they completed cleaning tasks. Record review of the facility's cleaning schedule dated 02/04/2024, reflected the initials indicating completion of the following: Ice Machine, Door, inside and out. Clean & Restock Coffee/Juice Area. Cleaning of the walk-in cooler and dry storage areas were not noted on the cleaning schedule. Record review of the facility's policy titled, Recommended Storage Practices, revised 2017, reflected, A. Dry: tore all foods six inches above the floor and eighteen inches below the sprinkler heads, on shelves, racks, dollies, or other surfaces which facilitate thorough cleaning, in a ventilated room, not subject to sewage or wastewater back flow or contamination by condensation, leakage, rodents, or vermin. Store all packaged food, canned foods, or food items in clean and dry place at all times. *Keep shelving and floor clean and dry at all times. *Schedule cleaning of storage room at regular intervals. *Do not store scoops in food containers. C. Refrigerated: .Schedule regular cleaning of refrigerators . (continued on next page)

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	676352	A. Building B. Wing	03/07/2024

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	IV: Food Storage: .The Nutrition Services Manager (NSM) is responsible for proper storage of nutrition services food and supplies . Record review of Federal Drug Administration Food Code, reflected, section 4-601.11 Equipment, Food-Contact Surfaces, Nonfood-Contact Surfaces, and Utensils revealed (A) EQUIPMENT FOOD-CONTACT SURFACES and UTENSILS shall be clean to sight and touch. (C) NonFOOD-CONTACT SURFACES of EQUIPMENT shall be kept free of an accumulation of dust, dirt, FOOD residue, and other debris. 3-305.11 Food Storage. (A) Except as specified in (B) of this section, FOOD shall be protected from contamination by storing the FOOD: (1) In a clean, dry location; (2) Where it is not exposed to splash, dust, or other contamination. 14 Food Preparation. During preparation, UNPACKAGED FOOD shall be protected from environmental sources of contamination. 3-307.11 Miscellaneous Sources of Contamination. FOOD shall be protected from contamination that may result from a factor or source not specified under Subparts 3-301 - 3-306. 3-602.

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	676352	A. Building B. Wing	03/07/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 35152 Based on Observation, interview, and record review, the facility failed to dispose of garbage and refuse properly for one of one trash bin and trash corral reviewed garbage disposal. The facility failed to ensure trash, in the dumpster coral, was contained and maintained in a sanitary condition. This failure could place residents at risk of unsanitary conditions. Findings included: An observation on 03/05/2024 at 8:45 AM, revealed the gate to the trash corral in back of the facility to be open. Although the trash bin was closed, trash and broken furniture littered the open coral area. Rubber gloves, plastic cups and bottles, food wrappers, food waste, wheelchairs and parts, and reclining chairs in various conditions. In an interview on 03/05/2024 at 08:45 AM, the Dietary Manager stated the coral gat should be closed and there should not be any food waste or trash of any kind on the ground in the corral. He said coyotes were known to come to the back of the facility, likely attracted by trash in the coral. He said the bins and the coral should be closed to minimize the possibility of attracting pests and rodents. He said because the bins were used by all facility departments, he thought he, the Housekeeping, and Maintenance Directors were responsible to ensure the trash area was clean and free of spilled trash and debris. He said he trained his staff on the need to ensure the area was kept clean and secure. He said he did not know if other department heads did the same. In an interview on 03/05/2024 at 02:11 PM, the Maintenance Director stated the trash coral gates should be closed at all times. He said he went to look at the area and saw the spilled food, trash, and broken furniture. He said the facility had a shortage of storage, so staff often placed broken furniture and equipment in the coral. He said he did check the coral from time to time and had pressure washed it in the past. He said it was important to keep the area clean to prevent the attraction of pest and rodents. He said he did not keep a log of the power washing, but his department and the kitchen staff alternated this task so both maintenace and kitchen staff were responsible to ensure the corral was kept clean. He said he had not had any formal / recorded in services but reminded his staff verbally on several occasions. In an interview on 03/05/2024 at 02:52 PM, the Administrator said all staff were responsible to ensure the trash bins and corral were kept clean and free of spilled food and other trash. He said he had not had a written in-service but had a verbal discussion with department heads to ensure they checked the area frequently. He said he expected maintanence and kitchen staff to ensure the area was kept clean. He said he did randome grounds checks to ensure the areas outsidet the facility were clean. He said it was important to keep the area clean to limit the attraction of pests and rodents. (continued on next page)

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	676352	A. Building B. Wing	03/07/2024

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	In an interview on 03/07/2024 at 07:31 AM, the DON said she did not follow up with the trash disposal issues. She said the facility was limited on space which could be why broken equipment was in the trash coral. She stated she would expect that anyone who placed trash in the bins would be responsible to ensure the area was kept tidy, free of debris, and secured. Record review of the facility's policy titled, Maintenance Service, revised December 2017, reflected, Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. c. Maintaining the fire alarm system and emergency generator system in good working order. d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. e. Maintaining lighting levels that are comfortable and assuring that exit lights are in good working order. f. Establishing priorities in providing repair service. g. Maintaining the paging system in good working order. h. Maintaining the grounds, sidewalks, parking lots, etc., in good order. i. Providing routinely scheduled maintenance service to all areas. j. Others that may become necessary or appropriate .

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	676352	A. Building B. Wing	03/07/2024

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Make sure that a working call system is available in each resident's bathroom and bathing area. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 35152 Based on observation, interview, and record review, the facility failed to allow residents to call for staff assistance through a communication system which relays the call directly to a staff member or to a centralized staff work area for one (room [ROOM NUMBER]) of twenty-nine rooms reviewed for resindet call systems. The facility failed to ensure room [ROOM NUMBER] had a working call light. This failure could place residents at risk of not being able to have their needs met and call for staff assistance when they needed it. Findings included: An observation on 03/06/2024 at 8:30 AM revealed the call light outside the room of #233 did not work. This surveyor pushed the call button in the room and the red light on the wall in the room came on however the light outside the room did not. An interview on 03/06/2024 at 8:30 AM, with the resident who resided in room [ROOM NUMBER] stated the call light had not worked for a few days. The resident said when she pushed the button, the call button indicated it was on, in the room, but no one responded. She said she had not told any staff about it. An interview and observation on 03/06/2024 at 8:35 AM, with LVN A revealed she was not aware the call light did not work. LVN A went into room [ROOM NUMBER] and pushed the call button then came outside the room and stated the light in the hall should be on but was not. She said the call light in the hall should light up to alert staff, the resident needed assistance, when in the hall. She said all call lights needed to work so residents were able to alert staff for assistance when they needed. She stated she would alert maintenance. An interview and observation on 03/06/2024 at 8:40 AM, with ADON B revealed she was not aware the call light in the hall outside room [ROOM NUMBER] did not work. ADON B also pressed the call button in room [ROOM NUMBER] and said the light outside the room should light up but did not. ADON B then went to the nurses' station to check the call light panel. The panel light for room [ROOM NUMBER] was on. She stated although the call light for room [ROOM NUMBER] worked at the nurse station, the light outside the room should also be on to ensure staff who were in the halls were notified that the Resident in room [ROOM NUMBER] needed assistance. She said staff were instructed to log any maintenance concerns in the logbook at the nurse's station. (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview on 03/06/2024 at 9:19 AM, the Maintenance Director stated he was having issues finding replacement parts for the call light system. He said he replaced the call light fixture outside room [ROOM NUMBER] with an after-market fixture on 12/19/2023. He said on 1/24/24 he replaced the bulb for the call light outside room [ROOM NUMBER]. He said he replaced the bulb again on 2/29/2024 but did not initial the maintenance log noting that it had been completed. He stated he thought it may be a spring, where the bulb attached to the fixture, that caused the problem. He stated staff were required to enter any maintenance issue in the logbook and he checked he book daily to address needed repairs. He said he initialed the logbook when repairs had been completed. He stated he did a random check on call lights every two weeks to ensure they were working but he had been having issues with the light outside room [ROOM NUMBER]. He said residents needed to have a working call system to ensure they could call for assistance when they needed. In an interview on 03/06/2024 at 1:25 PM, the Administrator stated he expected staff to note any maintenance concerns in the Maintenance Logbook at the nurses' stations and Maintenance staff to address the concerns timely. He said he also implemented Concierge Rounds, where facility management were assigned rooms to check daily. He said management staff had a form to complete for each room which addressed environment, safety issues, and clinical and dignity issues. He said each manager brought their forms to the morning meetings where concerns were discussed and follow up planned. He said the Executive Assistant was responsible for room [ROOM NUMBER] and he was not made aware of the call light issue. In an interview on 03/06/2024 at 2:32 PM, the Executive assistant stated she was responsible to complete Concierge Rounds for rooms #228 - #233. She said the purpose of completing rounds daily was to identify any issues the resident may have or maintenance concerns with the room. She said she last completed the rounds about 8:40 AM on 03/06/2024 and was not aware that the call light outside room [ROOM NUMBER] did not work. She said she normally checked call light but did not recall having checked the call button on 03/06/2024 or 03/05/2024. She said residents needed a working call light to ensure they were able to call for assistance when they needed to. In an interview on 03/07/2024 at 7:31 AM, the DON stated the facility did not have a specific call light policy, but she expected the call lights to work. She said the call light should light up outside the resident room and at the nurse's station. She said Concierge rounds were done daily to help to identify maintenance issues, ensure quality and address any concerns residents may have. She stated residents needed to have a working call light to ensure staff were aware of any need they may have. Record review of the Maintenance Logbook at the nurse's station reflected the following entries: 12/19/23, room [ROOM NUMBER], call light is not working, followed by the Maintenance Director's initials. 1/24/24, room [ROOM NUMBER], call light bulb is out, followed by the Maintenance Director's initials. 2/21/24, room [ROOM NUMBER], the call light bulb is out, followed by the Maintenance Director's initials. 2/29/24, room [ROOM NUMBER], Bed light on bed B is out, no initials noted. 3/5/24, room [ROOM NUMBER], call light bulb is out again, no initials noted. Record review of the facility's policy titled, Maintenance Service, revised December 2017, reflected, Maintenance service shall be provided to all areas of the building, grounds, and equipment. 1. The Maintenance Department is responsible for maintaining the buildings, grounds, and (continued on next page)

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	equipment in a safe and operable manner at all times. 2. Functions of maintenance personnel include, but are not limited to: a. Maintaining the building in compliance with current federal, state, and local laws, regulations, and guidelines. b. Maintaining the building in good repair and free from hazards. c. Maintaining the fire alarm system and emergency generator system in good working order. d. Maintaining the heat/cooling system, plumbing fixtures, wiring, etc., in good working order. e. Maintaining lighting levels that are comfortable and assuring that exit lights are in good working order. f. Establishing priorities in providing repair service. g. Maintaining the paging system in good working order. h. Maintaining the grounds, sidewalks, parking lots, etc., in good order. i. Providing routinely scheduled maintenance service to all areas.